NAME OF PROVIDER OR SUPPLIER

PRINTED: 10/12/2011
FORM APPROVED
OMB NO. 0038 0391

ENTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 15G787	a. building 00 b. wing	COMPLETED 09/09/2011
	_	STREET ADDRESS, CITY, STATE, ZIP CODE	

5515 TOMAHAWK TRAIL **AWS** FORT WAYNE, IN46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE W0000

W0000

9, 2011.

Facility number: 012483

Provider number: 15G787

This visit was for a fundamental annual

recertification and state licensure survey.

Dates of survey: September 6, 7, 8, and

AIM number: 201011380A

Surveyors: Kathy Wanner, Medical Surveyor III-Team Leader

Susan Reichert, Medical Surveyor III

reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/16/11 by Ruth Shackelford, Medical Surveyor III.

The following federal deficiencies also

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Based on record review and interview, the

system for payment of client liability, for

governing body failed to establish a

The governing body must exercise general policy, budget, and operating direction over

TITLE

012483

AWS does not require the clients

to pay fees, they are charged by

the bank as account fees. AWS

has informed all guardians and

(X6) DATE

10/09/2011

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

the facility.

W0104

W0104

li '		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING	00	COMPL		
		15G787	B. WIN	NG		09/09/2	U11 
NAME OF 1	PROVIDER OR SUPPLIEF			1	ADDRESS, CITY, STATE, ZIP CODE		
414/0					OMAHAWK TRAIL		
AWS				FORT	VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	clients of the bank fees		DATE
		om the facility was			associated with their banks		
	1 ^ ^	nyee which enabled the			accounts at the time they cho	ose	
		eir liability without			AWS to become their		
		ents to pay a money order			Representative Payee. AWS		
		k fee for 3 of 4 sampled			does not maintain bank acco		
	clients (clients #	1, #3, and #4).			representative payee for. A		
	Findings include				will be mailed to all consume	rs	
	Tindings include	·			and their guardians who hav chosen AWS to be their Soci		
	The financial red	cord for client #1 was			Security Representative Pay		
	reviewed on 9/7/11 at 11:48 A.M. and indicated the following: On 6/27/11 client #1 paid an \$8.00 fee for a cashier's check to pay her client liability. On 7/26/11				about their bank fees. This v		
					be signed and returned as po that they have been informed		
					agree to the payment of bank		
					fees that will be associated very their account and that AWS very	vith	
	1 ^ -	\$4.00 fee for a money					
		client liability. The bank		make every effort to minimize fees while providing maximum account security per the Social Security Representative Payee			
		ent #1 indicated the name					
		ount was in the name of					
	client #1 and the facility.				Guidelines. The Residential		
					Director will maintain all form and make certain they are in		
	Client #1's finan	cial record indicated the			financial section of the clients		
		ial agreement dated			for review.		
	I -	e [name of facility] staff					
	1	maintain, and close					
		ne of bank] according to					
	_	imer Account Agreement.					
		d and agree to the					
		e signatures of the					
		e of facility] staff					
		re the only authorized					
	1 -	hecking and/or savings					
	1 -	Il be accepted by my					
	financial institut						
	imanoiai mstitut	1011.					
	1				<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	DING	00	COMPL	ETED	
		15G787		B. WING		09/09/2011	
		<u> </u>	1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		5515 TO	OMAHAWK TRAIL		
AWS					VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	<b>+</b>	cord for client #3 was	-	IAG			DAIL
		/11 at 11:48 A.M. and					
		lowing: On 5/10/11 client					
	_	00 fees for 2 (two) money					
	1	r client liability. On					
		3 paid a \$4.00 fee for a					
	1 - 1	pay her client liability.					
		ent for client #3 indicated					
		bank account was in the					
	name of client #	3 and the facility.					
	Client #3's finan	cial record indicated the					
	following finance	ial agreement dated					
	_	e [name of facility] staff					
	the right to open maintain, and close						
	1 .	ne of bank] according to					
	_	ımer Account Agreement.					
		d and agree to the					
		e signatures of the					
		e of facility] staff					
		are the only authorized					
	1 -	hecking and/or savings					
	1 "						
	accounts that will be accepted by my financial institution."						
	imanciai mstitut	1011.					
	The financial red	cord for client #4 was					
	reviewed on 9/7/	/11 at 11:48 A.M. and					
	indicated the following: On 6/27/11 client						
	#4 paid an \$8.00 fee for a cashier's check						
	to pay her client liability. On 7/26/11						
		\$4.00 fee for a money					
	_	client liability. The bank					
		ent #4 indicated the name					
		ount was in the name of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE.			ETED		
		15G787	B. WING			<del></del>	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OMAHAWK TRAIL		
AWS				1	VAYNE, IN46804		
					W/ (114E, 11440004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	client #4 and the	facility.					
	Client #4's finance	cial record indicated the					
	following financi	ial agreement dated					
		[name of facility] staff					
		maintain, and close					
		-					
	-	e of bank] according to					
		mer Account Agreement.					
	I also understand						
	condition that the	e signatures of the					
	designated [name	e of facility] staff					
	representatives a	re the only authorized					
	signors for my ch	hecking and/or savings					
	-	l be accepted by my					
	financial instituti						
	imanciai mstituti	ion.					
	The Ames Design	al Davidantial Dinastan					
	_	al Residential Director					
	` /	erviewed on 9/7/11 at					
		en asked about the clients					
	paying fees for n	noney orders and cashier's					
	checks to pay the	eir liability payments, the					
		t is a bank fee. The client					
	accounts are set i	up according to federal					
	regulations."						
	10guiations.						
	1 1 2 1(-)						
	1.1-3-1(a)						
W/0140	The facility must d	evelop and implement					
W0149		d procedures that prohibit					
		lect or abuse of the client.					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
<b> </b> 15G787		B. WIN			09/09/2	011	
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					OMAHAWK TRAIL		
AWS				I	VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
			W	0149	AWS has a policy for the		10/09/2011
		review and interview, the			prevention and reporting of	of Ahuse	
	facility failed to	ensure the direct care			and Neglect. The staff who	1DU3C	
	staff were follow	ring the Group Home			violated that policy was		
	Abuse and Negle	ect Policy as indicated in			suspended pending the		
	1 of 24 Bureau o	of Developmental			investigation and terminated		
		ices (BDDS) reports for 1			employment with AWS once allegation was substantiated		
	of 4 sampled clie	· / 1			staff have received a refresh		
		(			training on the Abuse and N		
	Findings include				policy and their obligation to		
	1 mamgs merade	•			report. The clients were als	0	
	Facility records	were reviewed on 9/6/11			reminded about telling a		
	1 -	uding the BDDS reports			supervisor if anything unusu uncomfortable occurred in the		
					home. Post-tests were give		
		es of 1/13/11 and 9/6/11.			staff to ensure their		
	The BDDS repor	rts indicated the			understanding of the policy and		
	following:				their obligation to report immediately Ongoing compl	iance	
	- a BDDS report	dated 3/26/11 for an			will be monitored by the		
	1	/11 at 8:42 P.M. indicated			Residential Director.		
		ras reported to the					
		ctor (RD), that a staff					
		at #1's] group home spoke					
	· -						
	in an inappropriate manner towards [client #1]." The staff was put on administrative						
		nal investigation was					
	initiated.						
	DDD 2 2 11	. 1 . 1 4 4 4 4 4					
		y-up report dated 4/1/11					
	indicated the alleged verbal abuse was						
	substantiated and the staff's employment						
		During the course of the					
	investigation and	other incident of possible					
	abuse was report	ted by one of [client #1's]					
	housemates on 3	/26/11. The housemate					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G787	(X2) MU A. BUIL B. WING	LDING	NSTRUCTION  00	(X3) DATE COMPI 09/09/2	LETED
NAME OF I	PROVIDER OR SUPPLIER		•	5515 TC	DDRESS, CITY, STATE, ZIP CODE DMAHAWK TRAIL VAYNE, IN46804	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	(X5) COMPLETION DATE
	name so all staff were put on leave one staff membe was "braiding [cl spray bottle and in the face." Due of the interaction was terminated." the incident, but terminated from facility.  The facility Grown Neglect Policy don 9/7/11 at 1:19 indicated the foll facility] does not form by any persephysical abuse, witnesses, observing neglect of a client immediately to the [name of facility].  An interview was on 9/8/11 at 5:00 staff had follower RD stated, "No." had completed at allegation was for and all three staff.	ber the staff person's who worked on 3/26/11 e. Multiple clients and r confirmed a staff who lient #1's] hair using a d sprayed her (client #1) to the "inappropriateness the staff's employment The staff who witnessed did not report it, was also employment with the hap Home Abuse and ated 3/11, was reviewed P.M The policy owing: "[Name of tolerate abuse in any son. This includes rerbal abuse if any staff was or suspects abuse or at, they are to report this heir supervisor and the p.M When asked if d the agency policy the The RD indicated they in investigation and the bund to be substantiated if had been terminated at with the facility.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0G8Z11

Facility ID:

012483

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G787			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/09/2011
NAME OF F	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
AWS				OMAHAWK TRAIL NAYNE, IN46804	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LGG DENTERVING BUTCOM ATTOMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION
TAG	1.1-3-2(a)	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0G8Z11

Facility ID:

012483

If continuation sheet

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